STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

RE: Application for New /Renewal of a Nursing Staff Agency Licensure

Dear Administrator:

Enclosed is an application for the new/renewal of your State of Maryland Nursing Staff Agency license. Please complete the entire application. Incomplete applications will be returned.

After review of the application and receipt of the application fee of $150.00, a license will be issued. Any agency changes must be reported to this office as soon as possible.

If questions should arise concerning these forms, please contact Rita Plummer at (410) 402-8038.

Sincerely,

Barbara Fagan
Program Manager
Ambulatory Care Program

BF: vw

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AMENDED INFORMATION
NURSING STAFF AGENCIES

On November 16, 2007, the Secretary of Health and Mental Hygiene adopted:

1) .01-.10 under COMAR 10.07.03 Nursing Staff Agencies.

2) New Regulations .01-.10 under a new chapter, COMAR 10.07.03. Effective Date: December 17, 2007. The proposed regulations will affect Nursing Staff Agencies that provide or refer licensed or independent care facilities as temporary employees or independent contractors.

If your agency is currently providing services as defined, or if your agency is planning to provide services in the future, then it is required to obtain a Nursing Staff Agency license issued by the Office of Health Care Quality.

A Nursing Staff Agency must comply with the Code of Maryland Regulations 10.07.03, Nursing Staff Agencies. Regulations may be purchased for a fee of $5.00, in the form of check or money order made payable to the Department of Health and Mental Hygiene. Regulations may be accessed on line at: http://www.dhmh.state.md.us/comar/ and are also available in public libraries.

The Office of Health Care Quality has developed an application that a Nursing Staff Agency must renew for a one year license, active from the date of issue. Agencies that do not notify the department of certain changes in information on file may be fined $100.00. Prior to receiving a new or renewal license, an application must be completed. Any agency failing to comply with the new changes will lose the privilege of providing services in the State of Maryland. Under Article §10.10, any agency found providing services without a license may be subjected to a fine of up to $1000.00 for the first offense and $10,000.00 for each subsequent offense.

Sincerely,
Barbara Fagan
Program Manager

Rita
Phone: (410) 402-8038
Fax: (410) 402-8213

APPLICATION/RENEWAL REQUIREMENTS

Please ensure that the appropriate fee is submitted with the application. Required fees are non-refundable. Make check or money order payable to: **Maryland Department of Health and Mental Hygiene**.

A. Application for license:

1. Prior to providing services, all Nursing Staff Agencies must be licensed by the **Office of Health Care Quality**. To obtain a license, a complete application form must be submitted with the required licensure fee of **$150.00**.
2. Policies and procedures must be submitted with the application in accordance with **COMAR 10.07.03.09**.

B. Renewal:

1. To renew, a complete application must be completed and mailed to the Office of Health Care Quality with the required fee of **$150.00**. The renew process **must** be completed prior to the expiration date printed on the current license.

C. Change Of Information, 10.07.03.07:

1. An agency shall notify the Office of Health Care Quality of any change in ownership, address or name of agency within thirty (30) days of said change.
2. Any change in agency ownership, name or address requires the issuance of a new license and fee of $150.00. If the change is the person who controls or operates the agency, the agency shall be considered a "New Agency" and the new owner shall comply with all regulations of this chapter when applying for a new license.

D. If the licensee fails to notify the Office of changes, the Office may impose a fine of $100.00. **Failure to report changes may result in a fine of up to $2,500.00.**

Ensure all required information and related documentation is submitted with the application.

Failure to complete the forms in their entirety may delay the application process.

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State of Maryland
Office of Health Care Quality
Nursing Staff Services Agency

Include your Policy and Procedures Hotline number for client complaints

In accordance with State regulations, the State of Maryland has established a Nursing Staff Services Hotline. The purpose of the Hotline is:

- To receive complaints about local Nursing Staff Services Agencies
- To receive questions about local Nurse Staff Services Agencies

The Hotline number is **1 (800) 492-6005**
All voice mail messages will be returned during the next business day.

Written complaints may be submitted to:

Barbara Fagan
Program Manager
Office of Health Care Quality
Bland Bryant Building
Spring Grove Hospital Center
55 Wade Avenue
Catonsville, Maryland 21228

The Office of Health Care Quality may also be reached at: **(410) 402-8040**
Monday – Friday
8 AM – 5 PM

OFFICE OF HEALTH CARE QUALITY
Nursing Staff Agencies Licensure Application

Under the provisions of Code of Maryland Regulations (COMAR) 10.07.03, application is herby made to operate a Nursing Staff Agency in the State of Maryland.

Please indicate if license is: New Application ____ Renewal ___ License Number: _____

Official name of agency: _____

Trading name (dba): _____

Business Address: _____
(Street) ***(City/State)*** ***(Zip)***

Mailing address: _____
(If different from above) ***(Street)*** ***(City/State)*** ***(Zip)***

_____/_____/_____
(Telephone Number) ***(Fax Number)*** ***(E-mail Address)***

After hours/Emergency contact number: _____

Regular business hours and days: _____

Administrators Name: _____

Identify all healthcare facility (ies) staff will be referred to: _____

_____

_____

Application fee of $150.00 must be submitted with the application (Fee is non-refundable).
Make check or money order payable to: Maryland Department of Health and Mental Hygiene.

1. Has any owner, officer, director, agency or managerial staff had a license revoked, suspended or denied by the Department of Health and Mental Hygiene within the last five years?

   (Yes) ___ (No) ___ If yes, please explain: _____

   _____

2. Does the parent company, owner, agent, officer, or managerial staff own or operate a health care facility/agency licensed by the Office of Health Care Quality or surveyed by the Officer of Health Care Quality?

   (Yes) ___ (No) ___ If yes, list: _____

   _____

OFFICE OF HEALTH CARE QUALITY
Nursing Staff Agencies Licensure Application

3. The agency hereby attests that it is in compliance with:
   - ✓ The Civil Rights Act of 1964;
   - ✓ The Rehabilitation Act of 1973;
   - ✓ The Americans with Disabilities Act of 1990; and
   - ✓ The Drug Free Workplace Act of 1988.

(Yes) ___ (No) ___ If no, please explain: _____

_____

4. Have the owners, officers, directors, agents, or managerial employees been convicted of a criminal offense involving any program under Title 18, 19, or 20 of the Social Security Act?
   ____ Yes ____No

"I/We _____
Do solemnly declare and affirm under penalties of perjury that the contents of the foregoing application are true to the best of my knowledge, information and belief. I understand that the falsification of an application for a license shall subject me to criminal prosecution, civil money penalties and or the revocation of any license issued to me by the Department of Health and Mental Hygiene.

1. Signature of Applicant: _____

   Title: _____

2. Signature of Applicant: _____

   Title: _____

Send Completed Application to: **Office of Health Care Quality**
Bland Bryant Building
Spring Grove Hospital Center
Catonsville, Maryland 21228

Barbara Fagan
Program Manager
Office of Health Care Quality

Rita Plummer
(410) 402-8038

_____
FOR OFFICE USE ONLY
Initials: _____ Date: _____ Amount Paid: _____

Renewal: _____ License Number: _____ Bank: _____

VERIFICATION FORM

Individuals providing services in the State of Maryland **must** be licensed/certified with the state. Please complete this form by listing the required information. It is the responsibility of the responsible party to verify the status of each employee. **(Please copy if additional pages are needed)**.

Name of Staff	Position (RN, LPN,GNA)	Maryland License Number	Expiration Date	Verification Date	Name of Person Verifying Info.

Signature of Verifying Party: _____ Date:_____

VERIFICATION FORM

Individuals providing services in the State of Maryland **must** be licensed/certified with the state. Please complete this form by listing the required information. It is the responsibility of the responsible party to verify the status of each employee. **(Please copy if additional pages are needed)**.

Name of Staff	Position (RN, LPN,GNA)	Maryland License Number	Expiration Date	Verification Date	Name of Person Verifying Info.

Signature of Verifying Party: _____ Date:_____

WORKERS COMPENSATION LAW QUESTIONNAIRE

Name of Facility: _____
Please type or print)

Address of Facility: _____
(Please type or print)

Do you have Workers Compensation Insurance for your employees? (Check one)

☐ **YES** ☐ **NO**

If you have answered **YES** (above), please provide the following information:

Policy Number: _____

Binder Number: _____

Insurance Company: _____

Effective Date: _____

Expiration Date: _____

If you answered **NO** above, please submit the attached Certificate of Compliance Application to The Workers Compensation Commission, ATTN: Certificate of Compliance Officer, 10 East Baltimore Street, Baltimore, MD 21202-1641. You will receive a Certificate of Compliance from the Workers Compensation Commission. When you receive this certificate, please mail a copy to the Office of Health Care Quality (OHCQ), Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228 or fax a copy to (410) 402-8213.

Please Note: Your license cannot be issued unless this form is completed, signed, dated and provided to OHCQ along with your "Certificate of Compliance", (if applicable).

_____ _____

Signature **Date**

Revised 2/18/09

STATE AFFIDAVIT

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable State Laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.

I certify that this agency is in compliance with administrative and procedural requirements pertaining to COMAR 10.07.03, Regulations governing Nursing Staff Agencies, in the areas of written administrative patient care policies and other organizational documentation.

I further certify that I will notify the Office of Health Care Quality if there are any future substantive changes in agency and operation that significantly affect policies and procedure that notice will be given, in writing, before the effective date of the change.

I hereby swear and affirm that I am over the age of 21, I am otherwise competent to sign this Affidavit, and that these statements are true and based upon my personal knowledge.

NAME OF AGENCY: _____

_____

SIGNATURE OF AUTHORIZED OFFICIAL TITLE DATE

OWNERSHIP FORM

THE COMPLETION OF THIS FORM IS NECESSARY FOR LICENSE RENEWAL. PLEASE ATTACH THE COMPLETED FORM TO YOUR LICENSE APPLICATION.

All spaces in this form must be completed. If a particular section does not apply, insert the phrase "Not Applicable" or "N/A".

LEAGAL NAME OF LECENSEE (Disclosing entity): _____

TRADING NAME OF LICENSEE: _____

TYPE OF BUSINESS ORGANIZATION OF DISCLOSING ENTITY (Check One):

☐ ***SOLE PROPRIETORSHIP***

Name of Owner: _____
Address of Owner: _____

☐ ***PARTNERSHIP***

Name: _____
Address: _____

NAME(S), TITLES(S) AND ADDRESSES OF PARTNERS AND PERCENTAGE OWNED IF 2% OR MORE		
Name and Title	**Address**	**Percentage Owned**

☐ ***CORPORATION***

Name: _____
Address: _____

NAME(S), TITLES(S) AND ADDRESSES OF PARTNERS AND PERCENTAGE OWNED IF 2% OR MORE		
Name and Title	**Address**	**Percentage Owned**
DATE OF CHARTER:	**DATE OF INCORPORATION:**	

☐ ***OTHERS (Specify)***

Should aforementioned corporation or partnership be wholly or partly owned by another organization, the following shall be completed with respect to the organization owning all or part of the disclosing entity: List percentage owned if 2% or more.

Name: _____
Address: _____

NAME(S), TITLES(S) AND ADDRESSES OF PARTNERS AND PERCENTAGE OWNED IF 2% OR MORE		
Name and Title	**Address**	**Percentage Owned**

INSTRUCTION SHEET

Please REVIEW INSTRUCTIONS BEFORE Completing the Certificate of Compliance Application

The Workers Compensation Commission will accept only the original application, (Do not fax, photocopy or electronically reproduce). Type or print LEGIBLY (or application may be returned without review). Complete application in its entirety.

Line #1 - Name of Company (If the company does not have a name leave blank)

Line #2 - Owners Name (If Corporation, list the name of a contact person)

Line #3 - Complete Business Address (P.O. Box Not Acceptable)

Line #4 - Complete Mailing Address

Line #5 - Phone Number (Pager Number Not Acceptable)
FEIN or Social Security Number required (If Partnership, please initial and list the last four digits of Social Security Number for each Partner.) If using a FEIN Number, Social Security Numbers are not necessary.

Line #6 - Check appropriate box (see back of Application). Additionally, where indicated, please complete and attach Exclusion Form C-16R.

Line #7 - Sign and Date (If Partnership, all Partners must sign.)

NOTE: Maryland Law §9-201 requires an employer with one or more employees to carry Workers Compensation Insurance. Any employer with Workers Compensation Insurance is to submit proof (Policy or Binder Number) of coverage to the Agency where they are applying for their license. DO NOT COMPLETE THE CERTIFICATE OF COMPLIANCE APPLICATION IF YOU HAVE INSURANCE COVERAGE. If you have any questions regarding the Certificate of Compliance, please call (410) 864-5297 or 1 (800) 492-0479 Tuesday and Thursday, 9:00 a.m. to noon ONLY. If you do not follow the aforementioned instructions, it may cause a delay in the processing of your application. Thank you for cooperation.

Licensing Agencys Stamp

APPLICATION FOR CERTIFICATE OF COMPLIANCE

(Please type or print legibly – Review instructions of reverse side prior to completing application)

1. _____
   Name of Business (If trading as self, leave blank)

2. _____
   Name of Owner(s) If a partnership, print each partners name (Attach separate sheet if necessary)

3. _____ _____
   Business Address (P.O. Box Not Acceptable) City State Zip Code

4. _____ _____
   Mailing Address City State Zip Code

5. _____ _____
   Phone Number (Pager Number Not Acceptable) FEIN **or** Social Security Number(s)

6. The above named business would qualify for a Certificate of Compliance for the following reason: (Check the appropriate box and do not modify or qualify the stated reasons in any way.)

   a. ☐ Sole Proprietorship: The business is a Sole Proprietorship with no employees.
   b. ☐ Partnership: The business is a Partnership with no employees other than the individual partners.
   c. ☐ A Maryland Close Corporation (Attach Exclusion Form C-16R): The business is a Maryland Close Corporation with no employees other than the Corporate Officers.
   d. ☐ Farm Corporation (Attach Exclusion Form C-16R): The business is a Farm Corporation with no employees other than the Corporate Officers.
   e. ☐ Professional Corporation (Attach Exclusion Form C-16R): The business is a Professional Corporation with no employees other than the Corporate Officers.
   f. ☐ Limited Liability (Attach Exclusion Form C-16R): The business is a Limited Liability Company with no employees other than the Limited Liability Company members.
   g. ☐ Casual Employees: The business only employs Casual Workers as provided in LE §9-205 and defined under Maryland Laws.
   h. ☐ Owner/Operator of Class F Vehicle: The business is that of an owner operator of a Class F (Tractor) vehicle and meets the requirements of exclusion as defined under LE §9-218.

I AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

7. _____ _____
   Signature(s) If a Partnership, all partners must sign (Use separate sheet if necessary) Date

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After careful review of this application and based solely on the information contained in or attached to this application, the application is ☐ **APPROVED** ☐ **DISAPPROVED**.

_____ _____
Authorized Signature Date

An applicant who receives notice of disapproval may: 1) reapply for a Certificate of Compliance or 2) appeal the rejection in accordance with §§10-222 and 10-223 of the State Government Article.

CERTIFICATE OF COMPLIANCE

Before a governmental unit may issue a license or permit to a business for the purpose of engaging in an activity in which the business might employ a covered employee, the business shall submit to the governmental unit:

- ✓ A Certificate of Compliance with this title, or
- ✓ A workers Compensation Insurance Policy Number or Binder Number.

If a business is not covered by a workers Compensation Insurance Policy, an application to secure a Certificate of Compliance shall be submitted to the Workers Compensation Commission pursuant to Labor and Employment Article §9-105. The sole purpose of a Certificate of Compliance is to identify those businesses which are not required to carry Workers Compensation Insurance coverage. A Certificate of Compliance is **not** Workers Compensation Insurance and is not binding on the Workers Compensation Commission under any circumstance.

Note: Maryland Annotated Code LE §9-201 requires a business with one or more employees to carry Workers Compensation Insurance.

Eligibility: A business may secure a Certificate of Compliance in the name of the business, only if:

(a) The business is a Sole Proprietorship with no employees;

(b) The business is a Partnership with no employee other than the individual partners;

(c-f) The business is a Farm Corporation, a Maryland Close Corporation, a Professional Corporation or a Limited Liability Company with no employees other than Corporate Officers or Limited Liability Company members who have elected, under §9-206, to be excluded from Workers Compensation coverage;

(g) The business is an employer of only "Casual Employees" as provided under LE §9-205 and defined in Maryland Law; or

(h) The business is an Owner Operator of a Class F (Tractor) vehicle who meets the requirements of exclusion as defined under LE §9-218.

Mail Application to: The Workers Compensation Commission
Attention: Certificate of Compliance Office
10 East Baltimore Street
Baltimore, Maryland 21202-1641

Facsimile Applications Will Not Be Accepted. Do not photocopy or electronically reproduce.

WORKERS COMPENSATION COMMISSION
10 East Baltimore Street
Baltimore, Maryland 21202-1641
TEL: (410) 864-5100 or 1(800) 492-0479
TTD (MD Relay Service): (800) 735-2258
http://www.wcc.state.md.us

Date Stamp – WCC Use Only

EXCLUSION FORM

Pursuant to the provisions of Labor and Employment Article §9-206 of the Annotated Code of Maryland, officers of a Closed Corporation, officers or members holding a 20% interest in a corporation that earns at least 75% of its income from farming (Farm Corporation), Professional Corporation, or Limited Liability Company are covered employees if the officer or member provides a service for monetary compensation. Such officers or members who satisfy the criteria of Labor and Employment Article §9-206(b) may elect to become excluded from coverage by filing this Exclusion Form with the Commission.

To exercise this option, any officer or member from the aforementioned types of organizations wishing to be excluded must sign this document. **NOTE: By signing this Exclusion Form below, each officer or member affirms under the penalties of perjury that the information contained in this form is true and correct as to that officer or member, to the best of the officers or members knowledge, information and belief.**

1. NAME OF COMPANY: _____
2. TYPE OF COMPANY (Choose) Farm Corporation | Close Corporation | Professional Corporation | Limited Liability Company
3. ADDRESS: _____

   CITY: _____ STATE: _____ ZIP: _____
4. PHONE NUMBER: _____
5. DATE OFFICERS/MEMBERS ELECT EXCLUSION: _____

Typewritten Name and Title of Officer of Member Electing Exclusion	Percentage of Ownership	Personal Signature

IMPORTANT: Submit original form to the Workers Compensation Commission, a copy to the Workers Compensation insurer of the corporation if applicable, and keep a copy for your files.